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Acute Infectious Laryngotracheobronchitis*

A STATISTICAL STUDY

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One of the most fulminating of all acute infectious diseases seen in infancy and childhood is acute laryngotracheobronchitis. The first accurate description of this disease was made in 1823 by Blaud.[1] In 1912 Jackson[1] gave the first account that was noted in the American Medical Literature. Since that time many reports and descriptions of this entity have appeared. The suddenness of onset, the severity and the high mortality rate have always made this disease a challenge to the clinician; and it has only been since the advent of chemotherapy and antibiotics that we have begun to make inroads into its staggering mortality.

From January 1944 to January 1949, 202 cases have been diagnosed as acute laryngotracheobronchitis at Children's Hospital. Included in this group because of the similarity of symptoms, course and treatment were 9 cases of acute epiglottitis. We are attempting a statistical study of these cases and a brief review of the literature in order to point out again the salient features of this disease and to discuss the treatment and mortailty in order that we might better organize a team to continue to force down its decreasing mortality.

The diagnosis of laryngotracheobronchitis is difficult to substantiate. It is generally given a group of symptoms. As a result thereof there would be a wide variation in degree and laxity in making the diagnosis. In studying the charts of the patients admitted here during the last five years, it was difficult to determine which should fall in this category because of the large number of different observers and the rarity of confirmatory laryngoscopic examinations. We have set up as the criteria for making this diagnosis, the history of rather sudden onset, inspiratory difficulty, hoarseness, croupy cough, evidence of obstruction to the airways and progressing severity of symptoms. Since many cases did not fulfill all of these requirements, and since there is a great variation in severity of this disease, they were divided into three categories, mild, moderate, and severe. Those who did not manifest severe respiratory distress, who responded within 24-48 hours to therapy and who were discharged within 5 days were classified as mild. Those cases with severe progressive respiratory distress and who responded to therapy without operative intervention were classified as moderate. The cases that progressed to tracheotomy and those that died were classified as severe. See figure 1.

Mild	56
Moderate	99
Severe	47

Fig. 1. Classification of cases according to severity.

Etiology: Many different bacteria may cause this clinical picture. Davies[2] reports streptococcus hemolyticus, staphlococcus aureus, and pneumococcus as the most frequent pathogens seen. Mac Cready[3] considers B.influenza most important. Walsh[4] incriminates staphlococcus aureus, and Jackson[5] streptococcus hemolyticus in 85% of his cases. Rabe[6] reported the most frequent etiologic agents in his series as virus, H.influenza and C.diphtheria. From his evaluation of symptoms, blood picture, bacterial flora of the pharynx, and response to treatment, he feels that most cases who were formally considered to be due to H.streptococcus, staph. aureus, and pneumococcus might easily be classified under viral etiology. We have made no attempt to add to or detract from his conclusions. Of the cases seen here 124 cultures were taken on admission. Table 1 lists the important pathogens found in order of their frequency.

Hemolytic Streptococcus	22
H. Staph. Aureus	21
Pneumococcus	10
C. Diphtheria	7
H. Influenza	6

Table 1. Organisms found on culture in order of frequency.

*From the service of Dr. Joseph Wall Children's Hospital, Washington, D. C.

The remainder of these cases might well be due to viral infections as described by Rabe.[6]

Age incidence: Even though this disease may infrequently be seen at any age, it is most commonly seen in children under three. Copeland[7] states that in the very young, the anatomy of the respiratory tract with the small caliber of the bronchial components, the imperfectly developed cartilages, the redundance of mucus membrane, the superabundance of lymphoid tissues and the extreme vascularity of all structures tend to add to the hazards of this age. Likewise the lack of natural immunity except artificially induced against diptheria probably plays some part. Of 202 cases 183 were three years or under and 19 were over three. The youngest noted was 7 weeks old, and oldest was 9 years old. See figure 2. For some unknown

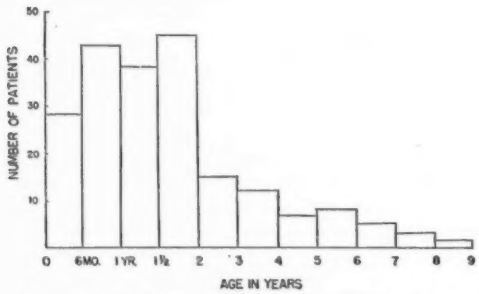

Fig. 2—Breakdown of Cases According to Age.

reason there was a predominance of males in this series, 146 against 56 females. Likewise there were 160 white patients and 42 colored. These results seem to be duplicated by practically all large studies.

Like all respiratory diseases the highest incidence is seen in the winter months, reaching its peak from November to March and then tapering off. See figure 3.

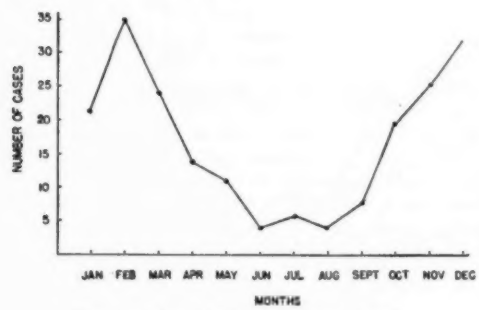

Fig. 3—Monthly Incidence of Cases.

Pathology: Definite bacteriologic and pathologic correlation in laryngotracheobronchitis has not been described in the literature to any great extent. This is due to the fact that until recently there was not too much agreement of the entity. There also has been little recognition of the bacteriologic etiology in the disease because of the lack of knowledge of the normal flora of the upper respiratory tract in children. Even with this knowledge no conclusion can be drawn unless in each group of cases a pattern of complete cultures is obtained. Then it is also evident that the presence of a potential pathogen may not necessarily indicate that it is the causative agent. It is agreed upon that the three most common pathogens found in laryngotracheobronchitis are C. diphtheria, H. influenza and hemolytic streptococcus.

In the series of cases under discussion no remark further than the fact that some potential pathogens were recovered in the majority of patients, can be made. Due to the lack of multiple histologic sections of the upper respiratory tract it is not possible to associate the bacteriology with the pathologic findings.

The pathology found in the sections from these cases does however fit the classical description of other authors. Involvement of the epiglottis, larynx, trachea, bronchi, bronchioles and alveoli is the basis of the altered pathologic physiology. Rabe describes in detail the principal difference in the pathology of so called "virus" influenza and diptheritic croup. He states that particular to H. influenza and absent in "virus" croup is the frequent occurence of marked to extreme supraglottic edema with epiglottitis, severe degeneration of the mucous glands of the laryngotracheabronchial tree early in the disease and the occurence of mucosal ulcerations secondary to submucosal abscesses. Diphtheria differs from the two with the presence early of a thick gray adherent membrane which forms at the pharynx and spreads downward, early degeneration of the mucous glands of the respiratory tract and more important changes outside of the respiratory system.

Symptoms: The clinical manifestations vary considerably in different patients. There is usually a history of mild upper respiratory infection with sudden onset of fever associated with hoarseness, cough and marked prostration. Dyspnea soon becomes evident. Initially the respiratory difficulty is mainly inspiratory due to the supraglottic edema,[8] but the distribution of the viscid secretions through the smaller bronchi is soon responsible for expiratory embarrassment as well. The cough may assume a croupy character. The bronchial secretions may be so extensive that they may obstruct the bronchial tree. With increasing edema of the laryngeal structures the dyspnea increases. The higher the obstruction is in the respiratory tract, the greater are the retractions. Table 2 shows the symptoms and signs noted here in order of frequency.

Mortality: There were a total of 28 deaths during this period, a total mortality of 13.8%. However, if the mortaility rate was compiled on the basis of the severe cases (47) as done by some authors, the mortality rate would rise to 59.5%. Since so many

Retractions	190
Pharyngitis	172
Fever (above 101)	162
Hoarseness	132
Croupy cough	140
Cherry red epiglottis	9
Membrane	8

Table 2. Symptoms and signs in order of frequency.

cases were admitted in extremist, it was decided that a corrective mortality would be necessary to give a better indication of the result of therapy. We have decided to use eight hours as the base line in formulating the true mortality. Since 16 deaths were under eight hours, the overall rate would be 5.8% and the limited rate (severe cases would be 25.5%. The following table will show the true and corrected mortality by year.

	1944	1945	1946	1947	1948
Total Cases	30	28	27	52	65
Deaths	5	3	5	4	11
Deaths under 8 hrs.	2	2	3	4	5
Total Mortality	16.6%	10.7%	18.5%	7.6%	16.9%
Corrected Mortality	10 %	3.5%	7.4%	0%	9.2%

Table 3A. Mortality all cases.

	1944	1945	1946	1947	1948
Total Cases (severe)	7	6	6	9	19
Deaths	5	3	5	4	11
Deaths under 8 hrs.	2	2	3	4	5
Total Mortality	71.4%	50 %	83.3%	44.4%	57.9%
Corrected Mortality	42.8%	16.6%	33.3%	0%	31.6%

Table 3B. Mortality severe cases.

The following chart adopted from Orton[16] will compare these mortality figures with others in the literature.

Author	Cases	Mortality	Year
Baum	24	41 %	1928
Gittens	32	39 %	1936
Smith	43	41 %	1936
Richards	28	40 %	1937
Brennerman	45	42 %	1938
Orton	62	28 %	1940
Davison	17	11.7%	1940
Howard[10]	44	6.3%	1940-43
Howard (severe)	20	35 %	1940-43
Davison[19]	52	0 %	1944-48
Children's Hosp.	202	13.8%	1944-49
Children's Hosp. (severe)	47	59.5%	1944-49

Chart 1. Mortality rates from literature.

Of the total number of deaths 7 were diagnosed as acute epiglottitis, and all died within 7 hours after admission to the hospital. The average length of time in the hospital of these cases was 2 hours.

Even though this disease is most common under 3 years of age, a check of these figures reveals the interesting fact that the mortality rate is highest above this age. Figure 4 shows the mortality rate per year of age, and figure 5 shows the percent mortality of these age groups.

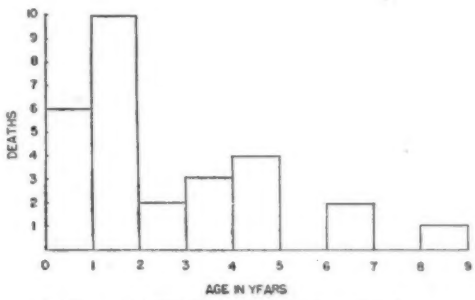

Fig. 4—Mortality Rate Per Year of Age.

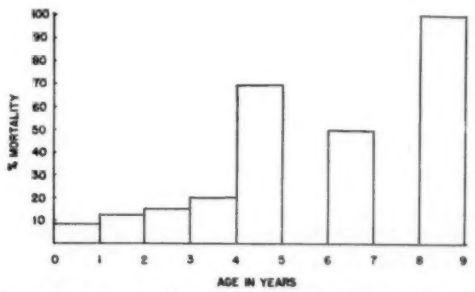

Fig. 5—Percent Mortality of Various Age Groups.

At autopsy the most prominent complications noted were atelectasis, pneumonia and dilatation of the heart. The latter was undoubtedly due to the marked respiratory and circulatory embarrassment which these patients have to undergo and which probably could have been circumvented if tracheotomies were done early. The following table will list the main complications seen at autopsy:

Pneumonia	12
Atelectasis	10
Dilatation of Heart	5
Myocarditis	4
Pneumothorax	2
Mediastinal Emphysema	1
Incision of Oesophagus	1
Toxic Nephrosis	1
Acute Proliferative Glomerulonephritis	1

Table 4. Complications noted at autopsy.

Treatment: The treatment of laryngo-tracheo-bronchitis has not changed much during the last 20 years except for the addition of new drugs. Jackson[8] feels that the most important single therapeutic measure, except in those patients who need tracheotomy, is the immediate placement of the patient in a room in which the atmosphere is saturated with moisture from a mechanical humidifier. This is a far advance over the steam tent which is unfortunately used here. Oxygen alone is a drying agent and is not indicated. The oxygen tent using controlled humidity as described by Davison[17] is excellent.

Sedatives in any form are contraindicated by most authors. However, while at the Willard Parker Hospital the author observed the use of whiskey, for the patient, in doses of 1 dram per year of age up to 4 drams with beneficial effects in allaying nervousness and restlessness in these patients. No evidence of respiratory depression was noted. Liquefying agents appear to have no effect on the sticky exudate seen in most cases. Constant surveillance by trained personnel and the proper use of suction can be very helpful at times.

Antibiotics and chemotherapy play an important part in our armamentarium. Since it is difficult to determine what organism one is dealing with until at least 24 to 48 hours, most authors agree that a "shot-gun" form of therapy may be indicated. Sulfa and penicillin have proved to be very effective agents. If H. influenza is suspected, streptomycin and rabbit antiserum may be indicated. It has not been proven as yet as to what role the newer drugs will play in this disease. However, we recently had an experience with aureomycin which proved to be very encouraging. A one year old male infant had been treated with penicillin, sulfa, streptomycin, tracheotomy, and supportive therapy for 96 hours and appeared to be sinking fast. He had several periods of cyanosis and had to be bronchoscoped twice. On the fifth hospital day, all medication was stopped, and as a last resort he was placed on aureomycin 20 mg. intramuscularly every two hours. At the end of 30 hours his temperature had fallen to normal and he showed remarkable improvement. Aureomycin was continued for ten days and the infant made an uneventful recovery. Since the throat culture contained non-hemolytic streptococcus and the blood count was only 12500 white blood cells, this may well have been due to virus etiology and the response to aureomycin might be accounted for in this way. We eagerly await the experiences of others in the use of this drug in this disease.

General supportive therapy is also of great importance. The use of fluids and plenty of rest are of great value. The treatments and medications should be so arranged so as to disturb the patient as infrequently as possible. Intravenous fluids should be used with great caution unless one overburdens an already overloaded circulatory system. Concentrated serum albumin has been tried by many to reduce edema of the larynx and was not shown to be of much value here.

Tracheotomy is one of the most potent weapons one has in the fight against this disease. The pediatrician must work hand in hand with the laryngologist so that this procedure might be done at a time that would be most beneficial for the patient. Neffson[9] states that the indications for operative intervention are signs of extreme obstruction and exhaustion. Table 5 lists the important features to be considered.

Signs of extreme obstruction:	
A.	Restlessness
B.	Cyanosis or marked pallor
C.	Deep retractions
D.	Absence of breath sounds
E.	Anxious facies
Signs of exhaustion:	
A.	Tachycardia
B.	Tachypnea
C.	Hyperpyrexia
D.	Stupor, coma, and convulsions

Table 5. Indications for Tracheotomy (Neffson).

However, one would not wait for all of these findings because the tracheotomy would be too late in most cases. It sometimes takes the "wisdom of a Solomon" to make this fateful decision. On too many unfortunate occasions, this is delayed too long. Suffice it to say that very close observation and cooperation by the pediatrician and laryngologist are most essential for the proper care of these cases.

It is beyond the scope of this paper to discuss the technique of tracheotomies. However, we would like to mention briefly one phase of this procedure. Mac Crady[3] states that tension pneumothorax and mediastinal emphysema were more prone to occur if bronchoscopy is done prior to tracheotomy. However, most authors[8,9,10,11,12] feel that the use of the bronchoscope prior to tracheotomy would tend to decrease the possibility of pneumothorax and should be done in all cases if possible. We concur with that opinion for the following reasons:

1. The bronchoscope furnishes an airway and relieves necessity for the so-called "emergency" tracheotomy.
2. It relieves the increased intrapulmonic pressure which according to Neffson[19] causes pneumothorax by distending and finally rupturing the pulmonary alveoli.
3. Makes it easier to find landmarks.
4. Allows for clearing of the airway before tracheotomy is done.
5. Simplifies the tracheotomy and lessens the danger of injury to adjacent structures.

During this five year period 29 tracheotomies were done here. Of this total 16 patients lived and 13 died.

This would give an apparent mortality of 44%. However, 7 of these were terminal which would give a corrected mortality of 20.7%.

Table 6 compares these figures with others in the literature—modified from Orton.[16]

Author	Cases	Tracheotomies	Deaths	Mortalities
Baum	24	17	9	53 %
Smith	43	12	4	33 %
Gittens	32	20	12	60 %
Richards	28	23	12	53 %
Brennerman	45	24	10	40.7%
Orton	62	20	7	35 %
Davison	17	9	1	11.1%
Howard[10]	44	16	4	25 %
Davison[19]	52	15	0	0 %
Children's Hosp.	202	29	13	44 %
Children's Hosp. (corrected)	202	29	6	20.7%

Table 6. Mortality rate from tracheotomies. (From Orton)

The duration of cannalization was from 4 to 22 days with the average of 10 days.

Complications that might be attributed to the tracheotomy directly were few in number. In the 16 cases that survived, mediastinal emphysema and pneumothorax were seen in one patient. In the 13 that died mediastinal emphysema and pneumothorax were seen in one patient, pneumothorax in one patient, and one patient had an incision of the oesophagus. The latter finding had no effect on the course of the disease in this patient, and the tracheotomy was done without the aid of an airway.

After an airway has been established by a tracheotomy, the most important task lies ahead—the proper care of the tracheotomized patient. It is most distressing to have a nurse assigned to the care of these patients, and when questioned, she will profess ignorance as to how she could take care of her patient. This situation has arisen on several occasions during the past year. This part of their curriculum cannot be stressed too strongly. In general, most authorities agree that constant capable nursing care is essential and may be life saving. The inner cannula should be removed and cleaned, and a small catheter should be used as often as necessary to aspirate the tracheobronchial tree. In many cases the use of a few drops of saline in the tube to soften the secretions would be helpful. Some authors recommend: 1:10,000 adrenalin,[13] weak solution of sodium bicarbonate,[14] or 1% ephedrine in normal saline[15] to accomplish this end. If obstruction persists it may be necessary for bronchoscopy to remove the crusts. The use of cold steam would also be helpful; oxygen alone is considered too much of a drying agent.

No discussion of therapy would be complete without a few words on the treatment of acute epiglottitis. Nine cases of this disease were seen here, and seven died within 7 hours after admission. One cannot stress too strongly the fact that these patients die from asphyxia very rapidly. If the diagnosis is made, an immediate tracheotomy is indicated. Watchful waiting with supportive and chemotherapy alone is contraindicated.

In order to alert and organize the personnel at this institution into an efficient team for the immediate care of these patients, an S.O.P. was drawn up early in 1948. It might be of some interest and value to reproduce it here.

1. The charge nurse, the resident and Asst. chief on the floor of which the patient is assigned will be notified immediately when the patient arrives on the floor.
2. The resident should see the patient immediately upon its arrival on the floor.
3. The following diagnostic and therapeutic procedures should be instituted immediately:
   a) direct visualization of the pharynx, larynx and epiglottis
   b) bacteriological smears and culture of the pharynx and epiglottis
   c) blood culture
   d) note the degree of cyanosis and record
   e) note degree of restlessness and record
   f) use of steam tent until cold steam is available
   g) immediate and adequate use of antibiotics and sulfadizine
   h) no sedation is to be used
4. Call E.N.T. consultant and inform him of status of patient.
5. Recommend immediate tracheotomy in any case of acute epiglottitis.
6. In presence of heart failure as evidenced by liver enlargement digitalization is indicated and a cardiologist should be consulted.
7. Excessive fluid should be avoided.
8. Excessive disturbance of the patient should be avoided. Administration of medications, parenteral fluids, examinations, etc. should be so planned as to cause a minimal disturbance to the patient.

Summary: A statistical study of 202 cases of acute laryngo-tracheo-bronchitis seen at Children's Hospital from Jan. 1944 to Jan. 1949 is presented with a brief review of the literature. H.streptococcus, H.staph.-aureus, C.diphtheria, and H.influenza were the most common organisms found here. A discussion of the mortality rate and autopsy findings was given. Pneumonia, atelectasis, and dilatation of the heart were the three most common complications noted. The treatment is discussed with special emphasis being placed on early tracheotomy, use of antibiotics, and proper post-operative care. The use of aureomycin is mentioned. Immediate tracheotomy in all cases of acute epiglottitis is recommended. An S.O.P. for the handling of these cases is presented.

The author is indebted to Dr. John E. Cassidy and Dr. Allen Walker for their helpful advice in the preparation of this paper and to Dr. D. Joseph Judge and the pathology department for the pathologic section of the report.

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An Unusual Cause of Tinnitus

A CASE REPORT

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A 53 year old white female was first seen on May 31, 1950 complaining of a roaring behind her left ear, and a thumping in the left occipital region for 7 to 8 months. She stated that the noise was worse at night and interfered with her sleep. She has been very nervous since the onset of the above symptoms, and finds that on any exertion there is an increase in the thumping and roaring. These symptoms have caused her considerable worry and have caused her to reduce her activities markedly. There is no pain or vertigo associated. There is no history of trauma. One of us (R.W.L.) on complete general examination noted that pressure over a certain place in the left occipital region caused cessation of the thumping and the noise. This roaring sound could be heard by placing the stethoscope over the involved region. Thereby, the patient's statement as to its presence and also as to its cessation on pressure over the point in the occipital region could be verified.

The patient was a white female, well developed, obese, 53 years old, in no acute distress but apparently worried. Blood pressure 162/80. General physical examination was essentially negative. A thrill and palpable pulse could be felt posterior to the left ear, synchronous with her pulse. The sound, of which the patient complained, could be heard with the stethoscope and it could be stopped by pressure over the point in the left occipital region. X-ray's of the skull revealed a rounded defect in the bone in the left occipital region. The diagnosis was made of an arteriovenous aneurysm between the occipital artery and the transverse sinus within the skull.

Under pentothol anesthesia the posterior aspect of the head and neck were prepared in the usual manner. The skin incision extended from behind the left

ear to the external occipital protuberance. The occipital artery and greater occipital nerves were identified. The artery was followed upward but the branch followed did not go to the aneurysm. The skin incision was extended from behind the left ear to the neck along the sternomastoid muscle. Here the main trunk of the enlarged occipital artery was identified and followed upwards. The artery passed inwards through the defect which was noted in the x-ray of the skull. The artery lay at the superior aspect of the bony defect and was about one fifth the size of the bony defect. Evidently the pulsations of the artery were eroding, the bone at its superior aspect accounting for the large hole in the bone, several times greater than necessary for admission of the vessel.

It was intended to perform an angiogram to demonstrate the arteriovenous communication between the occipital artery and the transverse sinus. The artery became very tortuous near its entrance into the skull so that when a needle was introduced into the vessel the side of the vessel was perforated. Henceforth diadrast could not be introduced sufficiently fast to get a satisfactory x-ray picture. In retrospect when one is absolutely certain that the correct vessel is at hand, all branches should be ligated distal to the point where a cannula is placed into the artery and fixed in situ. It is believed that by this method a satisfactory angiogram may be secured.

The occipital artery was ligated securely at its entrance into the skull at the bony defect. The defect was carefully examined. There was no evidence of any metastatic tissue being present. The defect, except where the artery perforated, was filled with fibrous tissue.

The patient was completely relieved of all noise in her head and it is believed that the relief will be permanent. Since relief of the tinnitus, the patient's nervousness has been markedly alleviated. This case was a relatively easy one to handle but it emphasizes the importance of checking all noises, tinnitus and etc., in the head against the pulse rate. A history of increase in noise on exertion and finding that the noise is synchronous with the pulse beat is diagnostic of a vascular origin of the abnormal sound.

Use of Methyl Testosterone in Premature Infants

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Claims for the beneficial effect of methyl testosterone in premature infants have been made and disputed. Shelton and Varden[1] found better survival, shortened hospital stay, minimized initial weight loss and increased rate of gain following administration of the drug. All infants in their group were fed routinely by gavage. Tittle[2] reached the same conclusion as to the value of the treatment and compared results in 18 cases with results in another group of prematures, but did not pair the controls with infants of similar weights. Hardy and Wilkins,[3] comparing alternate prematures and pairing the cases by weight, found no benefit from the use of methyl testosterone. Seitchik and Agerty,[4] could not demonstrate in a group of prematures the significant nitrogen retention which was thought to be the beneficial result from the use of the drug. No observer has noted any harmful effect.

This additional report is made on 20 premature Negro infants who were treated under identical conditions at Roper Hospital and were given 5 mg. of methyl testosterone orally and daily in a single dose. The drug was started as soon as milk feeding was established. Twenty prematures of nearly parallel weights were used as controls. None of these infants had any significant infections. None was fed by gavage except very occasionally. Facilities for care were not entirely satisfactory but were equivalent in the series.

As a basis of comparison, the grid for prematures as prepared by Dancis, O'Donnell, and Holt[5] was used, and the variation above or below the expected curve of gain was noted, as follows below. Weight in grams was recorded in round numbers by the closest unit of 5 grams.

Of the twenty Negro premature infants given methyl testosterone, 14 made significantly better gains in weight than did infants of approximately the same weight over the same length of time. Five of the controls gained better than did the five infants of equal weight who took the drug. In one pair there was no difference. No effect of the treatment was noted other than the gains in weight.

From the Department of Pediatrics, Medical College of the State of South Carolina.

The drug (oreton-M) was furnished through the courtesy of Schering Corporation.

Negro Premature Infants paired by approximate weight

Birth weight (Grams)	Methyl Testosterone	Variation from graph (Grams)	Age (days)
1956	+	+200	15
2098	0	— 25	15
1701	+	0	31
1673	0	— 50	31
1729	+	+400	23
1843	0	+ 50	23
2041	+	+225	21
1871	0	+ 50	21
1715	+	+300	22
1843	0	+150	22
2041	+	+ 50	16
2155	0	— 50	16
2027	+	+175	16
1956	0	+ 50	16
1219	+	+250	48
1247	0	—350	48
1928	+	+350	9
1928	0	— 75	9
1389	+	+300	40
1474	0	+250	40
1673	+	+125	31
1616	0	+ 75	31
2084	+	+ 75	11
2155	0	—150	11
1304	+	—100	28
1375	0	—150	28
1361	+	—100	50
1276	0	—150	50
2000	+	+125	15
2098	0	+150	15
1758	+	0	25
1843	+	+ 75	25
1829	+	—125	33
1885	0	— 50	33
1701	+	+125	24
1701	0	+475	24
2183	+	0	12
2225	0	+ 25	12
2027	+	— 50	23
1928	0	— 50	23

Summary

In a small group of Negro premature infants, methyl testosterone by mouth appeared to exert a beneficial effect in producing an acceleration in gain in weight in 14 out of 20 instances.

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Plan to Attend

Annual Meeting

S. C. Medical Association

Myrtle Beach

May 15, 16, 17

Surgery of the Newborn

N. D. ELLIS, M.D.
Florence, S. C.

Diagnosis of surgical conditions of a newborn and their treatment present problems significantly different from those in older children and adults. Proper pre- and post-operative management is of great importance in lowering the mortality.

Of all operable congenital deformities seen in the newborn infant, none is more difficult to handle than atresia of the esophagus with tracheo-esophageal fistula, which is an embryological defect with a communication between the trachea and esophagus. The infant with this condition is usually underweight and not infrequently premature. The operative repair is long and tedious and the post-operative course is stormy. Thus, it is no wonder that the mortality continues to be appalling.

A diagnosis of tracheo-esophageal fistula could so easily be made at the time of delivery if the possibility of such a deformity was considered in all newborn children who breathe poorly immediately after birth, have froth oozing from the mouth, and have cyanotic spells during the early hours after delivery. Unsucessful attempts to introduce a catheter into the stomach of such a child at once should arouse suspicion of congenital obstruction and the baby should be studied further immediately. Confirmation of the deformity is promptly established by introduction of a few centimeters of Lipiodol through a catheter into the blind pouch of the esophagus and taking an x-ray. Visualization of the blind upper end of the esophagus and the presence of air in the stomach or intestines make the diagnosis of atresia of the esophagus with esophageal fistula. However, if air is not seen in the gastro-intestinal tract, a diagnosis can be made of atresia of the esophagus without tracheo-esophageal fistula.

Operation on this type of case is long and tedious. The fistula is closed and an end to end telescoping technique of anastomosis is usually employed. The mortality rate runs around 50% in this type of case.

The second condition is intestinal atresia. Signs are manifested in the first days of life. Bile stained vomitus, which becomes progressively more frequent, is the first symptom. Also associated is abdominal distention, fever and absence of cornified epithelial cells in the stools during the first forty-eight hours. Primary anastomosis is the procedure of choice. The whole intestinal tract should be examined in that multiple atresias are frequently found.

The most common rectal anomaly is an imperforate anus with a rectal pouch ending blindly some distance above. Fistulas are frequently seen. Absence of an anal opening, failure to pass stools or mecomium, or its passage through an abnormal outlet are the usual early findings. Abdominal distention, vomiting, and later intestinal pattering are noted. The surgical treatment depends on the anatomic relationship of the rectum to the anal site.

Malrotation of the intestine usually causes external pressure on the second or third part of the duodenum and may become symptomatic during the first three or four weeks of life. It may simulate intestinal atresia during the first week due to the external pressure on the duodenum. Persistent vomiting, usually bile stained, abdominal distention, dehydration, gas-filled stomach and duodenum which are seen on x-ray, confirm the diagnosis. It is well to remember that volvulus may accompany this condition, as the small intestine is attached to the posterior abdominal wall by a very short mesentry.

Congenital diaphragmatic hernia must be considered with the symptoms of dyspnea, vomiting, cyanosis, which may occur only with feeding or crying, and may be relieved by turning the infant. Increased pulse and respiratory rates, decreased respiratory excursion, decreased or absent breath sounds with bowel sounds on the affected side may be noted. X-ray and fluroscopic study permit identification of the herniated structures. Immediate surgery is indicated in these conditions. Esophageal hiatus hernia should be treated surgically if there is evidence of gastric or intestinal obstruction at the hernial ring or if severe bleeding occurs from a mucosal ulceration.

Omphalocele or herniation of the abdominal contents covered only by peritoneum and amniotic membrane, can be diagnosed by inspection at birth and should be treated immediately with excision of the sac and replacement of the viscera into the abdominal cavity. There should be no delay in operating on these cases because after the thin, parchment-like membrane ruptures, a fatal peritonitis is usually the outcome. (We have had one case recently with recovery.)

Intussusception must always be thought of in a child with the symptom of pain and vomiting. The most common type is the ileo-colic. Bloody stools occur in approximately 85% of the cases after twelve to twenty-four hours of onset. A mass can be felt in the abdomen in the majority of the cases. Surgery, but no more than is absolutely necessary, is the treatment of choice. The operation should consist of reduction of the intussusception and nothing more. The mortality rate climbs rapidly with the passage of time in these cases.

Meckel's Diverticulum represents that portion of

the vitelline duct which opens into the ileum. There are several important pathological conditions which may arise from a Meckel's Diverticulum. Listed in the order of frequency are first, hemorrhage; second, the leading point of an intussusception; third, inflammation with or without perforation; fourth, umbilical fistula; and lastly, volvulus with infarction of the diverticulum. Treatment is surgery with removal of the Diverticulum and correction of any previously mentioned complication which may be present.

Duplication of the alimentary tract may cause symptoms and signs of abdominal obstruction, hemorrhage and abdominal masses on palpation. Surgical resection and side to side anastomosis should be performed.

Pyloric stenosis, characterized by a projectile vomiting containing no bile, usually begins during the second or third week of life. In addition, there is failure to gain weight, hunger, infrequent small stools, gastric peristaltic waves passing from left to right in the epigastric region, and a palpable pyloric tumor in the right upper quadrant in the majority of cases. It is more common in males and is treated by the Ramstedt type of operation. In the last eighteen months, we have operated on eight cases of pyloric stenosis with an excellent result in each baby.

Another condition which has been mentioned in the literature more frequently lately is congenital megacolon or Hirschsprung's disease. The etiology of this condition is thought to be neurological imbalance due to congenital absence of Auerbach's plexus in the intestine. Recent reports have shown that if the involved segment of bowel is resected back to the point where Auerbach's plexus appears in the intestine, an excellent result can be obtained in those cases coming to surgery.

Persistent jaundice first noted at birth or soon afterwards accompanied by splenomegaly, hepatomegaly, clay-colored stools, dark urine, and normal prothrombin time, usually characterize congenital biliary atresia. Physiological jaundice of the newborn, erythroblastosis, congenital syphilis and infectious hepatitis must be considered in the diagnosis. Exploratory laparotomy should be performed in all cases in which the diagnosis of congenital biliary atresia is entertained. Fifteen to twenty percent of cases are amenable to correction by surgery.

Inguinal and umbilical hernias only rarely come to surgery at this age unless they become incarcerated and cannot be reduced.

I hope I have brought to your attention some of those conditions occurring in the newborn infant which may be corrected by surgery. The interval from birth to diagnosis and treatment must be short if more of these babies are to be salvaged.

CANCER

Edited by R. W. POSTLETHWAIT, M.D., Charleston, S. C.

CANCER OF THE LARYNX

R. W. HANCKEL, JR., M. D.

Cancer in general is of particular interest to us at present for the following reasons:—

1. Cancer, as a cause of death, has risen from 8th to 2nd place in the last twenty-five years. One reason for this is the lengthened life span.

2. The public has been made cancer conscious by the extensive advertising campaign which is now in progress.

3. Cancer of the larynx, which is the major concern of this paper, is of interest because, in the majority of cases, hoarseness, an easily detectible sign, makes its appearance early and is constantly present until the condition is remedied.

It will be recalled that cancer of the larynx is divided into two main groups: one, *intrinsic* carcinoma which involves the true cords alone and particularly the free borders of the cords; and *extrinsic* carcinoma which involves the other laryngeal structures either primarily, or secondarily from neighboring areas.

The lymphatic supply of the true cords is a closed system and therefore metastases from malignancies occurring on the cords themselves develop late. On the other hand, the lymphatic supply of the other portions of the larynx intercommunicate freely and so metastases occur early.

Thus we have intrinsic (true cord) cancer which metastásizes late, but is detectible early because hoarseness is the first sign and is constantly present; and extrinsic cancer (involves other laryngeal structures) which metastazies early and is not usually detected until late, because hoarseness is not an early sign.

Fortunately eighty-five per cent (85%) of laryngeal carcinoma is intrinsic and therefore should be detected early enough so that surgery will be of benefit. Extrinsic carcinoma constitutes only fifteen per cent (15%) of these cases.

Unfortunately, hoarseness is a sign which is present in almost every organic lesion of the larynx. The general practitioner, who is usually our first line of de-

From the Department of Surgery and the Cancer Clinic, the Medical College of the State of South Carolina, Charleston, South Carolina.

fense in these cases, *frequently* sees patients whose major sign, hoarseness, clears up either spontaneously or with some minor help from the physician and so he comes to regard hoarseness lightly. If the general practitioner can be alerted in these cases and made aware that hoarseness that persists longer than a period of three weeks particularly in a male over 40 years of age should be adequately investigated, then much will be accomplished in bringing these cases to light early. Early detection and adequate therapy makes for a higher percentage of ten year cures.

Four to five per cent of all carcinoma of the body involves the larynx. Ninety-seven per cent of cancer of the larynx is found in males over forty-five years of age, and only three per cent in females.

The cause of carcinoma of the larynx is shrouded in as much mystery as is carcinoma elsewhere in the body. Chronic irritation which is frequently blamed as a causative factor in cancer elsewhere in the body cannot be indicted as a cause here. Tobacco and voice strain, the two most frequent causes of chronic laryngeal irritation, have been investigated by Martin at Memorial Hospital in New York. He found that the per cent of heavy smokers who had cancer of the larynx about equalled the number of heavy smokers who had no cancer of the larynx. He also found that of the numerous patients referred for voice strain (singers, teachers, hucksters, auctioneers, etc.) and who had frequent follow-up examinations for many years, only two developed carcinoma of the larynx.

Epidermoid or squamous carcinoma comprises about ninety-seven per cent of cancer of the larynx. Adenocarcinoma makes up only two per cent and lymphosarcomas and anaplastic carcinoma, the remaining one per cent.

As noted above, hoarseness is *the* constant symptom in all cases of intrinsic cancer. This hoarseness may begin as a slight huskiness and this may be relieved, at least partially, upon the administration of penicillin. This may lull one into a sense of false security. The hoarseness will progress to a complete aphonia. If a fungating type of lesion is present, the hoarseness may be accompanied by a gradually increasing dyspnea.

In extrinsic cancer of the larynx the first symptom usually found is pain. This may be present only on swallowing, or it may be constant, or it may be referred to the ear on the side involved, or any combination of these three may be present. Hoarseness is present in about one-third of the cases. The appearance of an enlarged lymph node is not infrequently found as the presenting symptom. The symptoms of the extrinsic variety, as indicated above, vary depending on the part of the larynx which is involved.

Once the suspicion is aroused that cancer of the larynx is present, every effort should be directed toward obtaining a complete view of the larynx. This may be accomplished in the majority of cases by the *indirect* method using a laryngeal mirror. The patient is seated opposite the examiner with the light about opposite the patient's *left ear*. The examiner sits facing the patient with a head mirror over his *right eye* and with the mirror so arranged that the pupil of the right eye is opposite the central opening in the head mirror so that binocular vision is obtained. The examiner then grasps a laryngeal mirror (size #4 or 5) in the right hand, pencil-fashion, about at the junction of the handle and the shaft of the mirror and warms it by dipping it in a bowl of hot water (wipe dry afterward), or by heating over an alcohol lamp or an electric light bulb. Be sure that the mirror is not so hot that it is uncomfortable to touch. The tip of the patient's tongue is then held between the thumb and forefinger of the examiner's left hand, the thumb being on top. The mirror is then introduced into the mouth over the dorsum of the tongue so that the back of the mirror presses the uvula up and back. The beam of light from the electric light is reflected by the examiner's head mirror on to the laryngeal mirror and is directed to the various parts of the larynx and hypopharynx by altering the angle of the laryngeal mirror. Usually it is necessary to look at the larynx several times before a composite picture is obtained. Some patients relax readily and a full view of the larynx can be obtained rather easily. Others require a spray of 2% pontocain to diminish the gag reflex. If the patient is asked to open his eyes and look at some fixed point such as the hole in the head mirror, relaxation is sometimes increased. During the examination have the patient first breathe easily, then say E-e-e-e not moving the tongue when this is done. This will cause the epiglottis to move forward and the anterior commissure can then be visualized. Also have the patient cough and laugh several times during the procedure, as this will aid in the complete visualization of the anterior commissure which is the frequent site of cancer of the larynx.

If a tumor is visualized a specimen may be obtained in the office. One uses mirror visualization except that the patient holds his own tongue with gauze held between the thumb and forefinger of the right hand. The examiner holds the mirror in his *left hand* and the biting forceps (mounted on a curved cannula and attached to a universal handle) in his right. A preliminary spray of 2% pontocain on the larynx until the cough reflex is abolished is usually necessary. This office procedure eliminates the expense of hospitalization for a direct examination and biopsy of the tumor. In all mirror examinations remember that the right side of the larynx is seen on the left side of the mirror and vice versa.

If it is impossible to get a complete view of the larynx with a mirror or if a biopsy cannot be obtained by the indirect method, the patient should be hospitalized and a direct laryngoscopy done.

The patient is instructed not to eat for several hours before the operation. He is given sodium amytal

gr. iiiss and atropine sulphate gr. 1/150 about forty-five minutes before operation. Some other pre-operative medication may be used but the author advises against the use of morphine if pontocain is to be used as the topical anesthetic. This combination has been known to produce fatal results.

The patient is advised to cooperate as much as possible by relaxing and breathing quietly. The larynx is anesthetized by introducing pontocain 2% (or cocain 10%, if preferred) directly on the larynx until the cough and gag reflexes are abolished. Under sterile precautions, with the patient recumbent, the laryngoscope is introduced into the mouth, the epiglottis is exposed and lifted anteriorly with the tip of the laryngoscope. This brings the larynx into direct view. If a tumor is present a biopsy is taken using laryngeal cup forceps.

If a biopsy positive for carcinoma is obtained by either the indirect or direct procedure, no time should be lost in instituting the proper surgical procedure.

If only one cord is involved and the cord remains motile indicating that the arytenoid is not as yet involved, then a laryngo-fissure is the procedure of choice. This consists of a midline neck incision from the hyoid bone to the supra-sternal notch, splitting the thyroid cartilage in the midline, and doing a submucus resection of the involved cord. This is done under a local anesthetic.

If both cords are involved, a complete laryngectomy should be done. If only one cord is involved but is partially or completely fixed indicating extension into the arytenoid articulation, a complete laryngectomy also should be done. If in addition, one finds cervical node enlargement, then besides a complete laryngectomy, one should also do a bloc neck dissection on one or both sides. This may be followed by x-ray therapy.

The complete laryngectomy is also done under local anesthesia. A midline incision is used, the larynx is freed of its muscular attachments, the pharynx is opened, the larynx is then dissected free posteriorly and is amputated from the trachea just below the cricoid. The wound is closed in layers, being very particular about the closure of the pharyngeal mucosa so as to prevent the formation of a fistula.

After the removal of the larynx the patient is encouraged to develop an esophageal voice. This is best accomplished by teaching these individuals in a group, the teacher being a laryngectomee who has developed a good esophageal voice. Speech is produced in an individual with a normal larynx by the interruption of a column of air by the vocal cords in approximation. This produces vibrations in the column of air and this sound is molded into speech by the tongue, lips, etc. In a laryngectomee the column of air has been trapped in the esophagus and is liberated by belching. This column is interrupted by the approximation of the free borders of the crico-pharyngeus at the upper opening of the esophagus and this vibrating column of air is molded into speech by the lips and tongue as before. The only things that are different is that the source of the air is the esophagus instead of the lungs and the lips of the crico-pharyngeus muscle instead of the vocal cords set the column of air in vibration.

Before leaving this subject, it should be mentioned that Cunning and the radiology department at Manhattan, Eye, Ear and Throat Hospital have developed a technic of x-ray therapy in treating both early and late cancers of the larynx and they report a percentage of cures comparable to that obtained by surgery.

In general, it may be stated that the earlier the case is discovered and the more radical the treatment instituted, the less the chance for a recurrence. In other words, it has been found that many cases of laryngo-fissure require subsequent complete laryngectomy which makes for a poorer prognosis. If there is any doubt in the surgeon's mind, he is treading on safer ground if he performs a complete laryngectomy.

Summary:—Carcinoma of the larynx is discussed. It is emphasized that hoarseness is the predominant sign in cancer involving the true cords and the general practitioner should be on guard to investigate to its fullest all cases of hoarseness of more than three weeks in duration, especially those in males over 40 years of age. Methods of obtaining biopsies are described and the various types of treatment are mentioned.

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TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

The Journal of the South Carolina Medical Association

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MARCH, 1951

THE BOLTON BILL

Congresswoman Bolton has introduced a bill in Congress which would provide federal aid to nursing education. Under the terms of the bill, nurses training schools would be given so much per student with an additional amount for increased enrollment. Provision is also made for funds to be used in expanding the facilities and curricula of the schools. The program would be administered by the Surgeon General of the Public Health Service, with the advice of an Advisory Council composed of thirteen members, eight of whom would be nurses. The Advisory Council would be appointed by the Federal Security Administrator. To obtain funds under this proposed program, each school would have to be approved by the Surgeon General.

Since this bill has been endorsed by leading nurses organizations, and since nursing is the closest profession to medicine, we would do well to study the bill and its implications most carefully.

The prime reason given for this proposed program is that there is a definite dearth of nurses and that our schools of nursing are financially unable to meet the need.

With the argument that there is a need for more nurses, particularly in our present increased military program, we will not contend. But we are not certain that this shortage is due primarily to financial distress on the part of training schools, and we have been unable to find any competent study to prove the point. We feel strongly that all private resources should be exhausted before federal aid should be extended to educational institutions of any type, and that the aid should be given in such a way that no strings shall be tied to the school which would in any way dominate or restrict its administration or activities.

The portion of the bill, however which concerns us most is that which gives to the Surgeon General the authority to approve or disapprove a school in terms of financial aid from the federal treasury. It is true that the bill provides for an Advisory Council composed largely of nurses, but the Surgeon General is under no obligation to follow the advice of the Advisory Council, and further the members of the Advisory Council are appointed by the Social Security Administrator—who at the present time is Mr. Oscar Ewing.

Training schools for nurses are now accredited on a state level by state board of nurses examiners. Leaders in the nursing profession are anxious to have a national accrediting agency such as prevails for medical schools. But the accrediting of medical schools is done by a non-political body with physicians having a voice in determining the membership of that body. The body is composed solely of individuals who are thoroughly acquainted with the problems of medical education and its sole concern is that of standards of medical education. It is absolutely incapable of weilding either political or financial pressure on schools to force them to follow a given course.

If leaders of nursing desire accrediting of training schools on a national level they would do well to follow the example of physicians in establishing their own agency. To endorse a federal bureau as the accrediting agency to accomplish their end, is to sell their birthright for a mess of pottage.

The problems which nurses are facing have been of keen concern to us over a period of years and we have endeavored to work with nurses in attempting to solve these problems. We congratulate them upon the advances which have been made. But as they face the immediate future with its uncertainties, we beg of them that they think not of the months ahead but of the years to come. Enactment of the Bolton Bill would seem to accomplish for the nurses that which their own efforts have been unable to obtain, but it might well result in the loss of freedom which is so dear to the heart of professional men and women. The thought of having the training schools for nurses in this country under the domination of a political bureau in Washington is abhorent to us, and it is our considered opinion that the rank and file of both graduate and student nurses are in agreement with us. And we also believe that leaders in the nursing profession, once they realize what the enactment of

the Bolton Bill could mean to their training schools and to their colleagues, will withdraw their support. We hope that this realization will not come too late.

THE SCRIBE

It is with genuine pleasure that we salute the newest member of the medical publication family in this state, The Scribe. Published by the Medical Society of South Carolina (the Charleston County Medical Society), it promises to be a real addition to the medical activities of the state.

Dr. J. I. Waring, Editor, and Dr. J. A. Seigling, Business Manager, are to be congratulated upon the appearance and content of the first issues. It is both interesting and informative, and bears careful reading. We will look forward to further issues with keen anticipation.

AMERICAN MEDICAL EDUCATION FOUNDATION

Since the end of World War II, rising costs, inflation, decreased income from endowments and fewer large benefactions have created major financial problems for the medical schools. The schools have found it difficult to purchase new and replace old equipment . . . to provide salaries adequate to attract and hold competent teachers . . . to maintain libraries . . . and to modernize or expand their physical facilities.

The American Medical Association believes that the possibilities of securing adequate support from private sources are far from exhausted. It believes that once the need is made clear to the medical profession . . . and also to those outside the profession who value the contribution of our medical schools to society . . . adequate funds from voluntary sources on a continuing basis can be secured.

The medical profession has a primary responsibility of leadership in securing such funds. At its meeting in Cleveland in December 1950, the Board of Trustees of the American Medical Association with the unanimous and enthusiastic approval of the House of Delegates voted to appropriate one half million dollars as the nucleus of a fund for the unrestricted use of the medical schools during 1951. The Board of Trustees, in announcing this appropriation, expressed the conviction that the members of the profession would greatly supplement this appropriation by individual contributions.

Our medical schools stand in need of additional financial support if they are to continue to provide the American people with more and better physicians. The tremendous advances in raising our health standards in the last fifty years have been due in large measure to the great improvments in medical education. Adequate financial support of our medical schools is, therefore, essential to the continued advancement of the nation's health.

The American Medical Education Foundation has been chartered as a not-for-profit corporation under the laws of the state of Illinois to receive annual contributions from physicians and friends of the medical profession. The Commissioner of Internal Revenue has been asked to rule that contributions to the fund will be deductible for the computation of income taxes.

Contributions received by the Foundation will be distributed to all approved medical schools in the United States. The funds will be given for unrestricted use—each school being entirely free to determine how best it can use its share to improve the basic training of its medical students.

It is recognized that the members of the medical profession alone cannot meet all the needs of the medical schools. Others must help. If the medical profession will lead the way, many others should be eager to make their contributions. By such a combined effort success can be achieved.

Each member of the medical profession recognizes a debt to the medical schools with which he has been associated as student, intern, resident and practitioner. Every member of the profession must also recognize that without strong medical schools the future capacity of the profession itself to serve society will be in jeopardy.

MINUTES OF CALLED MEETING OF HOUSE OF DELEGATES 1/28/51

The meeting was called to order at 3:15 p. m. at the Columbia Hotel by Dr. Tuten, President.

The Credentials Committee reported 42 delegates present.

The Secretary read the notice of the called meeting and its purpose. The floor was then extended to Dr. J. K. Webb, Chairman of the Committee on the Care for the Indigent, who explained, in detail, the report presented to Council at a recent meeting.

The report was then discussed and questions were asked regarding it, by the following doctors: Dr. Maguire of Charleston, Dr. Tom Brockman of Greenville, Dr. J. R. Young of Anderson, Dr. R. C. Smith of Conway, Dr. Joe Waring of Charleston, Dr. Jeff Chapman of Walterboro, Dr. Wallace of Spartanburg, Dr. Wallace of Chester, Dr. Lesesne Smith of Spartanburg, Dr. Joe Cain of Mullins, Dr. Thackston of Orangeburg, Dr. Wyatt of Greenville, Dr. Polk of Spartanburg, Dr. R. C. Smith of Conway, Dr. O. B. Mayer of Columbia, Dr. Evatt of Charleston, Dr. Price of Florence, Dr. Henson of Rock Hill, Dr. Bethea of Latta, Dr. D. O. Winter of Sumter, Dr. Hugh Smith of Greenville, Dr. Preacher of Allendale.

It was moved by Dr. Wyatt of Greenville, seconded

by Dr. Brockman, that the plan, as presented by this Committee, be adopted by the House of Delegates. The vote was 27 in favor, 18 opposed.

Dr. Julian Price then moved, seconded by Dr. Thackston, that the recommendation of the Committee be drafted in the form of a bill and presented to the Governor for passage by the Legislature. This was passed.

Another matter was brought up but unanimous consent of the convention could not be obtained, so it was dropped.

Adjournment at 4:45 p. m.

Respectfully submitted,
N. B. Heyward, M.D., Secretary

SOUTHERN PEDIATRIC SEMINAR

The annual Southern Pediatric Seminar will be held in Saluda, N. C. for two weeks, beginning 16th. Present indications point to a large registration and those who plan to go should communicate with Dr. D. L. Smith, Registrar, Spartanburg, S. C.

Last year for the first time the Pediatric Seminar was followed by a one week Obstetric Seminar and this will be given again this year.

GRADUATE SURGICAL ASSEMBLY

The Graduate Surgical Assembly of the Southeastern Surgical Congress will be held at Hollywood, Fla. (Hollywood Beach Hotel), April 11-14, 1951. Thirty-seven distinguished speakers from various parts of the country will appear on the program.

Those desiring information about the Assembly should communicate with Dr. B. T. Beasley, 701 Hurt Building, Atlanta 3, Ga.

BRODIE C. NALLE LECTURE

The second Brodie C. Nalle Lecture, sponsored by The Nalle Clinic Foundation, will be presented at the Hotel Charlotte on Friday, April 27, 1951, at 8:00 P. M. The speaker will be Dr. Samuel A. Cosgrove of Jersey City, New Jersey.

Dr. Cosgrove's subject for the Brodie C. Nalle Lecture will be "The Clinical Management of Toxemia of Pregnancy." As he has a reputation of being an excellent teacher and lecturer, this presentation should be of great value to those physicians concerned with pre-natal care. All interested physicians are cordially invited to attend.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

STATE ASSOCIATION TO PROMOTE PLAN FOR INDIGENT CARE

The House of Delegates of the South Carolina Medical Association, in a special meeting on Sunday afternoon, January 28th, in Columbia, adopted by a vote of 27 to 18 the report of the Association's Committee on the Care of the Indigent. It thereby approved the plan proposed by the Committee and gave the Association's endorsement to the necessary legislation.

Dr. John K. Webb of Greenville, Chairman, and the other members of his Committee, Drs. J. B. Floyd, Winnsboro, E. C. Kinder, Columbia, George Smith, Florence, and W. O. Whetsell, Orangeburg, had made a careful and comprehensive study of the situation with respect to the hospital care of the indigent in South Carolina, and their report had been submitted to the Delegates in writing some ten days prior to the meeting. After full discussion, it was adopted by the House without change, and the Committee was directed to have the necessary bill drafted and arrange for its introduction in the General Assembly, with the understanding that it would have the benefit of the Association's endorsement in the effort to secure its passage.

The plan proposes to deal with the care of the medically indigent on a statewide basis. Following are some of the principal provisions:

The State will be asked for an appropriation of $1,000,000 to be allocated among the counties on the basis of population. Counties which wish to participate in the program will match the funds allocated to them by the State, and the money is to be used to pay the cost of hospitalization and drugs for the medically indigent.

If all the counties participate and match the million dollars to be appropriated by the State, this would provide approximately $1.00 per capita for the entire population, and that amount has been determined as the reasonable minimum necessary to take care of the medically indigent in South Carolina.

An Advisory Committee would be appointed, composed of 15 members, three of whom would be doctors recommended by the South Carolina Medical Association. In addition, the Committee would include two hospital representatives, one nurse, one pharmacist, and eight members-at-large.

Local advisory groups in the counties would be set up on generally the same basis, but of course would be much smaller.

Those who are medically indigent would be determined by the Department of Public Welfare after consultation with the statewide or central advisory committee. Hospitals would be paid a percentage of

"... it was discovered that Dramamine ... is a powerful preventive of motion sickness."

—Editorial: Dramamine,
GP 2.27 (July) 1950

DRAMAMINE®

BRAND OF DIMENHYDRINATE

—for the prevention and/or treatment of motion sickness

For the dizziness, nausea or vomiting caused by motion, Dramamine has given unusually satisfactory results, prophylactically and therapeutically. Supplied in 50 mg. tablets and in liquid form. G. D. Searle & Co., Chicago 80, Illinois

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

their per diem rate, the amount again to be determined by the Board of the Department of Public Welfare, after consultation with the central advisory committee.

A bill has been prepared and is expected to be presented to the Legislature in the near future. The plan was fully discussed by members of the House of Delegates. Those who favored it pointed to the urgent necessity of the adoption of some plan for the assistance of the poorer counties and it was the view of the majority that the plan proposed by the Association's Committee offered a very satisfactory solution. Thus, the State Association takes the initiative in another concrete effort toward the solution of a problem closely associated with the objectives of the medical profession. None of the funds to be appropriated if the bill is adopted, would be used to pay doctors. As in the past, their professional services would of course continue to be given free of charge to patients in these categories.

MANY MEMBERS PAY DUES

Response to the increased efforts on the part of the Treasurer and the Business Office to collect 1950 dues to both the State and the American Medical Associations has been most heartening. In the latter part of December letters were mailed to the secretaries of all county societies showing a list of their members who, up to that time, had not paid dues to the State Association or to the American Medical Association. The secretaries were asked to check these lists with their records and to inform the Business Office of any changes. Some of the secretaries responded and it was interesting to note that the officers of the larger societies were the most cooperative. Some changes were necessary because certain members had retired from active practice or had become entitled to Honorary status through continuous membership in good standing of the State organization for 40 years.

Following this letter and the response, reminders were mailed to all members who remained unpaid. Largely as a result of these efforts, the dues of 37 members of the State Association were received between the end of December and the 1st of March, and 72 members paid dues to the American Medical Association. This brings the total number of paid members in good standing of the State organization as of the latter date to 1,020. Of this number, a total of 970 have paid dues for 1950 to the American Medical Association. It will be necessary, therefore, for at least 31 more members to pay their dues to the A. M. A. if our two delegates are to be retained.

Dues for 1951 to both the State and National organizations became payable on January 1st. By March 1st, considerably more than $6,000 had been received for the new year, and additional collections are coming in regularly. Members are requested to bear in mind that payment of 1951 dues is a requisite to registration at the annual meeting. Payment in advance, in sufficient time for the county secretary to remit to the State office will facilitate the accounting and keeping of records there and decrease measurably the delay incident to registration at Myrtle Beach.

COOPERATIVE MEDICAL ADVERTISING BUREAU

The State Journal Advertising Bureau, formerly the Cooperative Medical Advertising Bureau, seems to be doing an excellent job in the securing and placing of advertising for state medical journals. According to the annual financial report for 1950, a total of 10,796 pages of advertising were placed through the Bureau, with a net return to the journal offices of $533,545.71.

The actual sales costs amounted to about 6.4%. According to Mr. Alfred J. Jackson, this is a very low percentage, the cost of selling advertising space, generally, being from 15 to 30% without certain detail services rendered by the Bureau.

Of the 39 state medical journals now being published, the Bureau serves 34, representing 42 state medical societies. The Journal of the South Carolina Medical Association is a member of the Bureau and its Editor, Dr. J. P. Price, has been on the Executive Board for several years. All the State Journal Advertising Bureau publications follow the advertising standards adopted for the publications of the American Medical Association.

AN ADDRESS delivered at the Statewide Press Conference of the Medical Association of Georgia, Atlanta, Monday, October 2, 1950.

DOCTORS AND THE PUBLIC

BY JOHN E. DREWRY

(Dean, Henry W. Grady School of Journalism, The University of Georgia; Vice-President, Association of Accredited Schools and Departments of Journalism; formerly President, American Association of Teachers of Journalism; Author or Editor, "Concerning the Fourth Estate," "Post Biographies of Famous Journalists," "More Post Biographies," "Book Reviewing," "Contemporary Journalism," etc.)

There is probably no name in medical history held in higher esteem than that of the late Sir William Osler, who practiced and taught at Johns Hopkins in Baltimore and at Oxford University in England. He was the author of a book, "Principles and Practice of Medicine," which was a basic text of thousands of contemporary practitioners, and was himself the subject of several important books, one of which, Dr. Harvey Cushing's "The Life of Sir William Osler," published in 1925, won the Pulitzer prize. So wise were Dr. Osler's observations on such a variety of subjects that only this fall—31 years after his death—a new book called "Osler Aphorisms" has ap-

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DEXTROGEN®

For Your Infant Patients

Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrins, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with 1½ parts of boiled water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.

The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

NOTE HOW SIMPLE TO PREPARE

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*

THE NESTLÉ COMPANY, INC.
COLORADO SPRINGS, COLORADO

peared, and undoubtedly it will have a substantial sale. The teaching and personality of this man, according to Webster's Biographical Dictionary, "strongly influenced medical progress," and it is for this reason, among others, that I turn to him for the text of my remarks on medical public relations.

The story is told (in "For Doctor's Only" by Dr. Francis Leo Golden) that one day as Dr. Osler was leaving the hospital, a patient called out from a nearby bed, "Good morning, Doc." The great physician made no reply, but when he reached a corridor, he turned to the interns who were accompanying him and said:

"Beware of the men who call you Doc. Rarely do they pay their bills."

This admonition, with all its public relations implications, is my text of the evening.

What does this statement mean? ("Beware of the men who call you Doc. Rarely do they pay their bills.")

Are doctors primarily interested in their fees?

Do they place money above human relationships?

Do they want the proper distance kept between them and their patients?

Are their ministrations, like their Latin prescriptions, to be expressed in a language classical and incomprehensible to the masses?

Above all, is the attitude of professional medicine toward the public, and the agencies of public relations, a little like that of big business of yesterday: "The public be damned!"?

And is this attitude, as was the case with the corporations, intensified by fear? In the case of business—fear of government intervention? In the case of medicine—fear, again of government, but in this instance known as socialized medicine?

Fear, undoubtedly, is at the bottom of much bad medical public relations. But it is more than fear of socialized medicine. It is a fear much more general and fundamental. It is the fear of the unknown, and in the case of most doctors, the unknown is public relations—its purposes and techniques. Coupled with this frightening ignorance are a training, a tradition, and an ethical concept which eschew publicity. Doctors don't advertise (openly) and they are suspicious of those who get into the public prints (no matter how dignified the reference or reputable the publication). Dr. Osler had something of this point of view—although printer's ink played a far greater part in the establishment of his great reputation than many doctor critics may realize. Wrote Dr. Osler:

"In the life of every successful physician there comes the temptation to toy with the Delilah of the press— daily and otherwise. There are times when she can be courted with satisfaction, but beware! Sooner or later she is sure to play the harlot, and has left many a man shorn of his strength, namely the confidence of his professional brethren."

The doctor does not, of course, want to be shorn of his strength—of his professional reputation. He is jealous of the esteem in which he personally and his profession are held. He wants, if he be the right kind of physician, to enhance the standing of both. The prescription then, is that of Holy Writ. "Heal thyself." "Know ye the truth and the truth shall make you free." He must analize the fears that are at the root of many of medicine's public relations problems; he must put into language those that have been unverbalized; he must deal adequately with those which merit attention; and he must free himself of the paralysis of what Roosevelt called the greatest of all fears—fear of fear itself—the professional equivalent of a child's fear of the dark.

What then is the treatment? There is no general panacea, and the several phases of medicine—general practitioner, specialist, hospitals, public health, nurses—all have their special problems. But there are a few general principles which may well serve as the basis of individual or group action.

Do you know and are you concerned about the answers to such questions as these:

What is it about doctors and medical practice that the public does not like?

Which of these complaints have merit, and what can doctors do about them?

What is the public?

Could it be that there is more than one public?

Are doctors, as such, aware of Capital and Labor, of civic clubs and veterans' organizations, of Congress and the Senate, of the Church and public education—and a host of similar groups, all of which are potential friends or enemies?

In the answers to such questions as these lies the beginning of wisdom in so far as good public relations are concerned. As another one of your speakers, Larry Rember of the American Medical Association, has so well put it, "Medical public relations is a continuous process by which the medical profession endeavors to obtain the confidence and good will of the public—inwardly by self-analysis and correction to the end that the best interests of the people will be served; outwardly by all means of expression so that the people will understand and appreciate that their welfare is the profession's guiding principle."

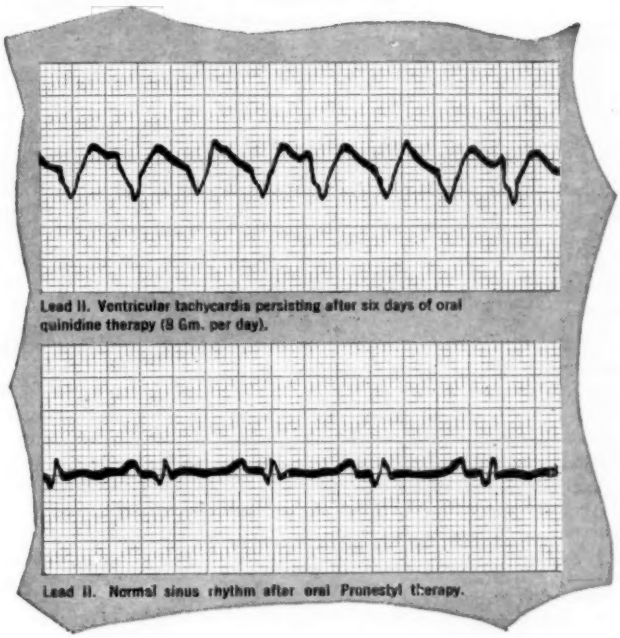
Did you notice that phrase—"by self-analysis and correction?" What are some of the areas in which doctors may well do some professional soul-searching? You know these, of course, better than I, a layman, would. But I have read some things that are not too complimentary to you about fees; about kick-backs in the sale of spectacles, drugs, and through referrals; about keeping patients waiting in your outer offices much too long; about treating the ailment rather than the person; about discourteous brush-offs of newspaper men whose missions are perfectly legitimate;

a new drug . . .

for the treatment of ventricular arrhythmias

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride



Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).

Lead II. Normal sinus rhythm after oral Pronestyl therapy.

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of blood count, urine, liver function, blood pressure, and electrocardiogram. Pronestyl may be given intravenously with relative safety.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.

SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

about unkind references to Reader's Digest, Time, and other publications which are making a serious and intelligent effort to work with and for the medical profession in the attainment of better health for more of the people; about a high and mighty and holier-than-thou attitude toward those whom you are pledged to serve and toward those social agencies, such as the press and radio, which should and would like to be your allies.

Many are the times that I have told our journalism students that the newspaper is for society what the doctor is for the individual, and that this is the age of preventive rather than curative medicine. The press is concerned with the ills of society, just as you are with the ailments of the individual—or states in the language of preventive medicine, the press would promote the health of the body politic just as you would see that the individual remains well. This means that the agencies of communication are potentially your friends. But you must know these agencies, and the men and women through whom they function, if you are to enjoy this friendship and its benefits.

It is not without significance that propaganda—which is just another word for public relations—is of religious origin. The word derives from the College of Propaganda which was instituted by Pope Urban VIII (1623-44) during the 17th century to educate priests. Propaganda or publicity is, therefore, a phase or form of education. And its greatest development has been during the present century. There are some fairly obvious and altogether logical reasons for this, among which are:

1. The complexity of modern civilization makes it impossible for any newspaper to cover all sources of news. This applies equally to the great metropolitan journal with its many reporters and to the small weekly with one man doubling in brass as reporter, editor, advertising and circulation manager, linotype operator, make-up, and press man. It applies also to press services, such as the A. P., U. P., and I. N. S., and to the magazines. Much worthwhile news, therefore, must be provided the press through public relations offices if it is ever to be published.

2. Specialized subjects—and certainly medicine is one of these—need to be treated by those who understand them. A few of the better-heeled newspapers and magazines are able to employ science and medical writers, but the rank and file of publications can do a better job of interpreting medicine to the public if the stories are processed for readability and truth by a public relations man or woman who has the point of view of both the doctor and the press or radio.

3. Institutions and professions supported by and/or serving the public—and these would certainly include hospitals, doctors, dentists, et al—have an obligation to keep their constituences informed how they are functioning—their problems, difficulties, and achievements.

4. From the doctor's standpoint—and this may be regarded as the selfish point of view, albeit enlightened selfishness—proper publicity is a lever for the kind of support which medicine, like all professions and social agencies, constantly needs. We have often heard that an offensive war is more easily and more successfully fought than a defensive one. Good publicity—continuous publicity— may be regarded as that offensive which will keep doctors on the victorious side in its many battles—be they against disease and death or the forces of socialized medicine.

5. An important reason for public relations development—one which doctors and others who are publicity shy are likely to forget—is that the newspaper, radio, and magazine, as important social agencies, cannot ignore medical, scientific and educational news. In terms of the onward march of civilization, it is the most important of all news. It is the main skein in the fabric of national and world progress. In the fulfillment of this obligation, journalists are entitled to the intelligent support of the medical world.

6. Possibly the strongest argument for active, aggressive medical public relations—and again this is from the standpoint of medicine, selfish, but enlightened—is the fact that publicity is a safeguard against misrepresentation. One reason that so many persons are sympathetic to socialized medicine may be that that side has been quick to appreciate the truth of this particular argument for propaganda and to put it to practical use.

Which brings us back to that word propaganda—indeed a tricky term. Some cynic has said that whether propaganda is good or bad depends on whether it is ours or that of the other fellow. Certainly the word means one thing for one group, and something entirely different for another. For many, it has an evil connotation. For them, it is something sinister, evil, under-cover, perhaps dangerous. For others (and we, I hope, belong to this group), it is a muchly abused word of honorable origin and great potential. It is a necessary part of our 20th century mores. It is ours to use wisely through many media.

The agencies of propaganda are many, and each has its special use. Newspapers and radio readily come to mind. So do magazines and pamphlets. But had you thought of schools and textbooks, popular best-sellers and college courses, the church and the movies, as tools of propaganda? Where have people learned so much about socialized medicine? Not in newspapers and magazines alone. Do you know what is being said on this subject in high schools, in university courses in the social sciences, in ladies' reading circles, and in civic clubs and on lodge night? The range, scope, and possibilities of public relations, my friends, are indeed far-reaching. Good propaganda is

they deserve the best . .

Implicit in a happy healthy childhood is maximal nutrition—and one of the essential dietetic guideposts to vigorous adulthood is adequate vitamin C[1,2,9] (¼-4 oz. for infants up to 1 year;[10,11] 4-8 oz. for older children).[4] Fortunately, most every youngster likes the taste of Florida orange juice and the "lift" its easily assimilable fruit sugars* provide.[6] It is well-tolerated and virtually non-allergenic.[3] And, under modern techniques of processing and storage—it is possible for citrus fruits and juices (whether fresh, canned or frozen) to *retain their ascorbic acid content,*[5,8] *and their pleasing flavor,*[7] *in very high degree and over long periods.*

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

Citrus fruits—among the richest known sources of Vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.

. . . plenty of citrus fruit

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FLORIDA
Oranges • Grapefruit
Tangerines

quantitative as well as qualitative, extensive and intensive. Are you making the most of your opportunities and obligations?

Medicine is one of the oldest of the professions, but one of the youngest to see the need of organized publicity. I was interested to read that it was only last year that the Medical Association of Georgia inaugurated a public relations program—thus becoming the 22nd such society to employ a full-time public relations director and the 32nd to set up a budget specifically for public relations activities. The church ministry, another old profession, is a newcomer to the public relations field. But much progress is being made. Some of the theological seminaries are adding courses in public relations to their curricula. Possibly medical schools should do likewise. I had a student tell me recently that he was planning to be an undertaker and that he thought journalism would be a good premortician's course. We now have a combination journalism-law course. Medicine, the ministry, and the law are, of course, the classical trilogy among the professions. Two have taken formal cognizance of the place of journalism or public relations of a part of their educational preparation of novitiates. The third, your profession, seems to be toying with the idea. It may not be a bad one.

In conclusion, may I point quickly to some of the good things by way of medical public relations which I think merit commendation.

1. Some of our best books are by doctor-authors. We all are familiar, of course with Dr. Frank K. Boland's "Crawford W. Long," and the tremendous amount of time and energy which Dr. Boland has exerted in behalf of Dr. Long's claim to fame as the first to use ether as an anesthesia. Incidentally, this is a good example of medical public relations at its best. We also remember the great biographies or autobiographies of Hugh Young, Harvey Cushing, the Mayo brothers, and other towering giants of medicine. Perhaps you doctors know, but I doubt whether the public does, that some of our best fiction writers have a medical background. To cite but three among contemporary best-sellers, there are Somerset Maugham, A. J. Cronin, and Frank Slaughter. If we turned back the pages of history, there would be Oliver Wendell Holmes and others of equal stature. Have you ever wondered why some of our best literature is medical in origin? (In the book trade, it is said that books by or about doctors, books about Lincoln, and books about dogs always sell well.) The answer may be in the fact that physicians know life with its ailments, problems, difficulties, achievements, and moments of happiness as no other professional group can. They know life and death and all that comes between. In the language of Robert Peter Tristram Coffin in his memorable poem, "Country Doctor"—

"Through rain, through sleet, through ice, through snow,
He went where only God could go . . .
He left an old man in the dark
And blew up a tiny spark
In a young man two feet long
To carry on the dead man's song . . .
He went to the country's ends,
Not for fees, but for friends,
Came like an angel fierce and fast,
He saw men first and saw them last . . .
Our farms so lonely and spaced far
Could never have grown the nation we are
But for this man, come sun, come snow,
Who went where God alone could go."

2. Our better magazines are devoting more space to your field. *Time*, I think, does a good job with its section on medicine. *Reader's Digest*—in spite of some doctors' cryptic and critical comments—has carried many excellent articles and has a point of view which is admirable. *Look* magazine, with its illustrated feature on the American Medical Association, and its current article by Margaret Mead on psychoanalysis, has shown enterprise and discrimination in its approach to health subjects. *Atlantic Monthly, Life, Saturday Evening Post,* and *Ladies' Home Journal* come to mind, and in the case of the realization of pure food and drug laws is indeed a milestone of great importance.

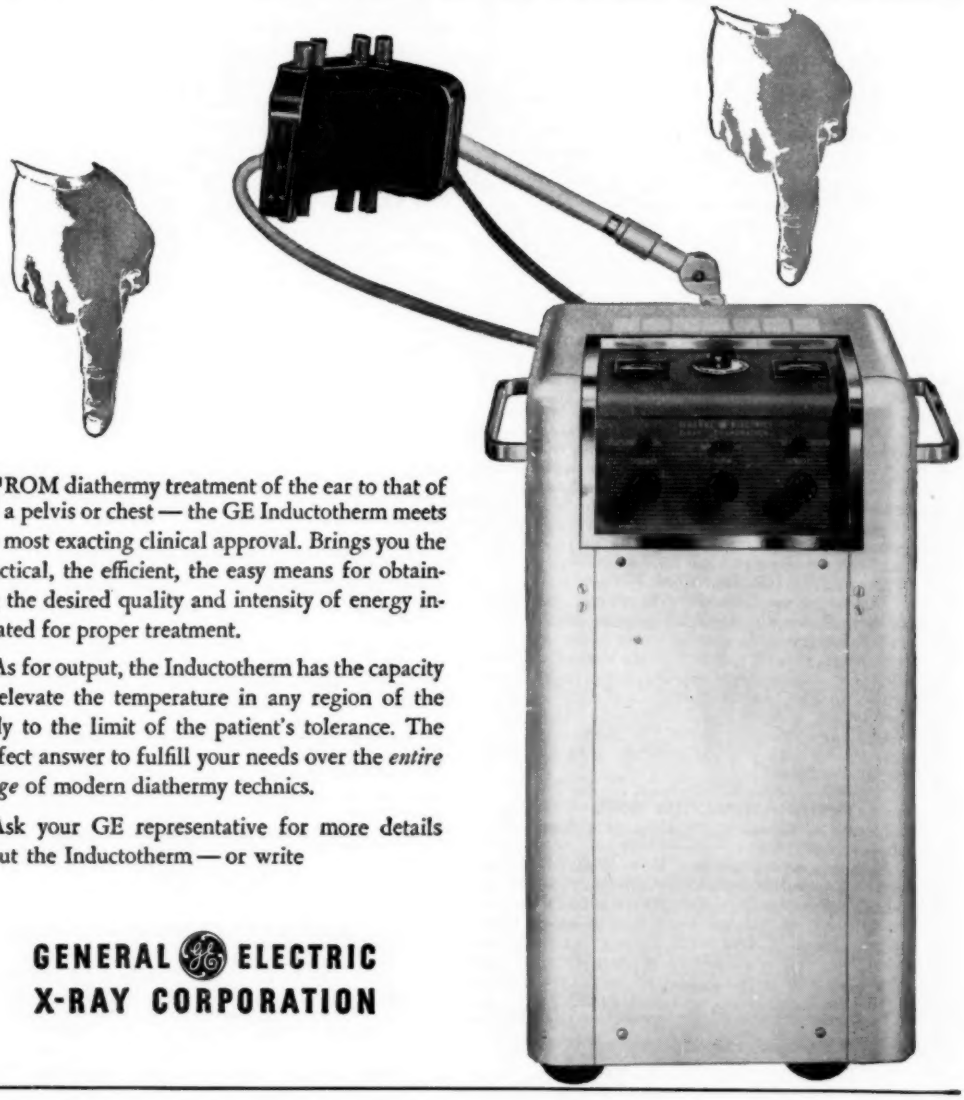
3. All over the country, those newspapers which are financially able to do so are adding reporters and special writers to handle hospitals, medicine, science, and related subjects. Our own Atlanta Journal has pioneered in this form of journalistic progress and has won sectional and national praise for its achievements in this realm.

4. Radio, through local and network programs, is giving more time and better talent to programs that relate to medicine and health. I remember that a Peabody winner in 1942 was "Our Hidden Enemy—Venereal Disease," Radio Station KOAC, Corvallis, Oregon, prepared by Dr. Charles Baker for the University of Kentucky.

5. Television, right here in Atlanta, has demonstrated its usefulness in revealing operation techniques. I was privileged, as were some of you, to see those marvelous demonstrations at the Municipal Auditorium and both the potentialities and actualities of those telecasts were impressive and far-reaching indeed.

There is much more that could be said about what medicine has already accomplished by way of good public relations and also about what is yet to be done. Possibly I have said enough for you to carry both themes forward in your own thinking. To close, I turn again to Sir William Osler—for whom I have great admiration, however much I may disagree with his statement which I used as the text for these remarks. Sir William once said:

Meets every requirement for all diathermy technics... the GE INDUCTOTHERM



FROM diathermy treatment of the ear to that of a pelvis or chest — the GE Inductotherm meets the most exacting clinical approval. Brings you the practical, the efficient, the easy means for obtaining the desired quality and intensity of energy indicated for proper treatment.

As for output, the Inductotherm has the capacity to elevate the temperature in any region of the body to the limit of the patient's tolerance. The perfect answer to fulfill your needs over the *entire range* of modern diathermy technics.

Ask your GE representative for more details about the Inductotherm — or write

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GREENVILLE — F. F. Chisholm, 204 Cureton St.

"Always note and record the unusual . . . communicate or publish . . . anything that is striking or new."

Did you note the key words in that injunction? The *unusual . . . communicate . . . publish . . . striking . . . new.*

How like the classical definition of news which is in every primer of journalism!

If a dog bites a man, it is not news, but if a man bites a dog, news it is.

The *unusual . . . the striking . . .* the *new.*

Perhaps medicine and journalism are not so far apart after all. Certainly both are concerned with human and social betterment. And, certainly, a working alliance between the two is possible without in any way jeopardizing the Hippocratic oath. Dr. Osler admonished: "Remember how much you do not know." Public relations is a new field. There is much yet to be learned. But progress is being made, and medicine in general, and you of the Georgia Medical Association, in particular, are to be congratulated on what you are accomplishing in this vital area.

DEATHS

ARCHIBALD EARLE BAKER

Dr. Archibald E. Baker, 54, died in Charleston on January 25 after several months of illness.

A native of Charleston, Dr. Baker was graduated from Davidson College and from the Medical College of S. C. (Class of 1921). Following postgraduate work in New York and at the Mayo Clinic, he returned to Charleston in 1923 to become associated with his father, the late Dr. A. E. Baker, in the practice of surgery. At the time of his death, Dr. Baker was president of Baker Sanitarium, a visiting surgeon at Roper Hospital, and a member of the surgical teaching staff at the Medical College. In 1949 he served as President of the Medical Society of S. C. (the Charleston County Medical Society).

"Archie," as he was known to a host of friends throughout the state was a lovable individual and a gracious host, and in his passing the physicians of the state have lost a loyal colleague. He is survived by his wife, Mrs. Ann Bissel Baker, two daughters, and one son.

ARTHUR ERNEST SHAW

Dr. Arthur Ernest Shaw, 75, oldest practicing physician in Columbia, died at his home on the afternoon of February 8.

Upon graduation from Jefferson Medical College in 1905, Dr. Shaw came to Columbia in company with the late Dr. George Bunch, and both of these men served for a period as assistants to the late Dr. LeGrand Guerry. Subsequently Dr. Shaw established his own practice in general practice with particular interest in roentgenology.

HENRY A. EDWARDS

Dr. Henry A. Edwards, 76, died of a heart attack on February 8.

Dr. Edwards was graduated from Wofford College and from Vanderbilt Medical College (1899). He opened his office in Latta in 1900 where he carried on the practice of general medicine up to the time of his last illness. Gifted with a keen mind and an observant eye, his services were in great demand and those who knew him recognized his as a true "family physician."

Dr. Edwards is survived by his widow, the former Miss Florence Mullins, and one son.

JOHN VICTOR TATE

Dr. John V. Tate, 70, died at his home in Calhoun Falls on February 6.

A graduate of Emory Medical School (1907), Dr. Tate had practiced at Calhoun Falls for over forty years. He was loved by those in his little community and in his death they have lost a real friend.

NEWS ITEMS

Dr. Paul P. Hearn is now associated with Dr. J. W. McLean of Greenville. Dr. Hearn's practice will be limited to otolaryngology.

Dr. Bruce Edgerton of Blackville has opened an office in Springfield.

Dr. William Craig, Jr. has resumed his practice in Pickens.

Dr. J. G. Sylvester has opened offices in Florence for the practice of surgery.

Dr. William Marion Bevis has joined the staff of the Edgewood Sanitarium at Orangeburg.

Dr. James A. McLeod of Florence has left his growing practice in Florence to join the medical corps of the United States Army.

Dr. P. J. Moore, Jr. of Pickens, was elected President of the Pickens County Medical Society for the year. Dr. C. E. Ballard was elected Vice President and Dr. W. R. Craig, Jr., Secretary-Treasurer.

The following physicians were elected officers of the Georgetown County Medical Society: President, Dr. E. T. Kelley; Vice President, Dr. Harry Tiller; Secretary-Treasurer, Dr. S. E. Miller.

Florence County Medical Society officers elected to serve in 1951 are: President, Dr. W. J. Jenkins, Olanta; Vice President, Dr. J. D. Ellis, Florence; Secretary-Treasurer, Dr. J. H. Stokes, Florence.

BIRTHS

Dr. and Mrs. L. E. Mays of Seneca, are the proud parents of twins, a girl and a boy, born January 20.

Dr. and Mrs. Hugh Smith, Jr., of Greenville, have announced the birth of a daughter, born January 20th.

Three babies were born in Greenville on January 22, all of them children of physicians as follows:
To Dr. and Mrs. M. Nachman, a daughter.
To Dr. and Mrs. Homer Parnell, a son.
To Dr. and Mrs. Thomas Parker, a daughter.
Was this Doctor's Day?

WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. F. Burnside, Columbia, S. C. **Publicity Secretary: Mrs. Weston Cook, Columbia, S. C.**

If winter comes—spring is just around the corner, and with the thought of spring comes the happy realization that the meeting of the Woman's Auxiliary to the South Carolina Medical Association is not far away.

It climaxes a year's hard constructive work for our President, and those associated with her; the reunion of old friends and the meeting of new ones. A time we've waited for with joy and anticipation.

The convention Committee has been working on plans for your pleasure and surprise, and although omnious war clouds again hang over our nation, we have gone forward with exciting plans as though Peace were reigning supreme.

So draw a red circle around these middle-of-the-month-of-May-days on your calendars, and come to this meeting to do honor to our President, Mrs. Alfred Burnside, who has given unstintingly of her time and talents to make our Auxiliary an even better and more efficient organization, and enjoy with her the fruits of her year's work.

The Convention Chairman, and each of her committee cordially invites you to be present at this meeting.

Place: Myrtle Beach
Dates: May 15, 16, 17
Elizabeth S. Durham
(Mrs. Robert B.)
Convention Chairman
Jerry Libbert
(Mrs. K. M.)
Co-Chairman

VOLUNTARY PLANS GROWING RAPIDLY

In an address delivered by Dr. Elmer L. Henderson, President of the American Medical Association, before the United Medical Service of New York, he emphasized the fact that within the ten year period that Voluntary Health Insurance Plans have been in effect, they have demonstrated their widely growing popularity. "At the end of 1949, we knew from the last annual report of the Health Insurance Council, more than sixty-six million Americans had some kind of voluntary insurance protecting them against hospital, surgical, or medical expenses. It is a conservative estimate, based on all known developments in 1950, that between seventy and seventy-two million Americans now have some form of Voluntary Health Insurance . . . . The prediction of medical economists . . . . that ninety million Americans will be protected by Voluntary Health Insurance within the next two or three years . . . . is well in its way to fulfillment . . . . and the advocates of socialized medicine are fast losing all semblance of a case."

From "A New Milestone in Prepaid Medical Care," an address by Elmer S. Henderson, M. D.

SUGGESTED BULLETINS TO BE USED

March Issue—Bulletin #1
Haddon Hall will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 11-14, 1951.

ENDORSEMENT CAMPAIGN ACCELERATED

Aware of the fact that Congressman Dingle has introduced a new bill for National Compulsory Health Insurance (H. R. 54), and knowing further that the Administration is still eager for the adoption of its socialistic legislative program, the Legislative Committee of the South Carolina Medical Auxiliary has accelerated its campaign for endorsements from S. C. organizations willing to take a stand against Compulsory Health Insurance. This letter has gone out to all County Chairmen of Legislation urging them to renew their efforts for endorsements. They have been asked to work particularly hard with the S. C. Parent-Teachers Groups. Local P. T. A. Groups cannot pass independent resolutions against socialized medicine, but they can approve a set of resolutions and express a desire to have the resolutions presented for adoption at the annual convention of the South Carolina Congress of Parents and Teachers to be held in Spartanburg in April. Doctors' wives can be of invaluable assistance by being present at their P. T. A. meetings and supporting the action when it is presented.

The services rendered in the community by the physician is so cheerfully, quietly, unassumingly given that few people realize until he passes on what a place of importance he has filled. In South Carolina there have been hundreds of these noble, self sacrificing men who have given their lives in service for their fellowmen. How can the Auxiliary to the South Carolina Medical Association do these men greater honor than by preserving their memories through biographies secured from relatives and friends to be placed in the Archives of the organization! These Archives will always be a permanent record of the achievements of these doctors of our State and source material for historians.

I should like to impress upon each member of the Auxiliary her responsibility in assisting the Historian of the local Auxiliary by furnishing her with information useful in writing biographical sketches of deceased physicians. I am sure she will welcome all the assistance you can give her.

Some of the older Auxiliaries have kept their records up to date; however, in those sections where Auxiliaries have recently been formed there should be much valuable data compiled this year, reaching far into the past, to those early physicians who served in the lower part of South Carolina in the "Horse and Buggy Days."

The County Historians would like to complete their records by April 1st and send their reports to the State Historian on that date, so if you have any information suitable for these biographical records please contact your local historian.

Below is a list of the County Auxiliary Historians:

ANDERSON
Mrs. Bruce Swain, Anderson, S. C.
1208 N. Main Street

CHARLESTON
Mrs. M. W. Beach, Charleston, S. C.
3 Glenwood Avenue

Carolina Rest Home Hospital

A COMPLETELY NEW FIREPROOF HOSPITAL—SPECIALIZING IN THE TREATMENT OF NERVOUS DISORDERS AND ALCOHOLIC PROBLEMS WITH A PERSONAL FOLLOW UP.

P. F. LaBORDE, M. D.
MEDICAL DIRECTOR

U. S. #1 South, Box 188
WEST COLUMBIA, S. C.

COSTAL
Mrs. W. A. Black, Beaufort, S. C.
EDISTO
Mrs. C. I. Goodwin, Orangeburg, S. C.
1077 Middleton, N. E.
GREENVILLE
Mrs. I. H. Grimball, Greenville, S. C.
210 Pine Forest Drive
PEE DEE
Mrs. James C. McLeod, Florence, S. C.
PICKENS
Mrs. N. C. Brackett, Pickens, S. C.
RICHLAND
Mrs. R. B. Durham, West Columbia, S. C.
R. F. D. #2
SPARTANBURG
Mrs. Wm. H. Folk, Spartanburg, S. C.
SUMTER
Mrs. W. A. Stuckey, Sumter, S. C.
Folsom Street
THIRD DISTRICT
Mrs. J. R. Power, Abbeville, S. C.
YORK
Mrs. J. L. Bundy, Rock Hill, S. C.
733 Eden Terrace

Plan to Attend

Annual Meeting

S. C. Medical Association

May 15, 16, 17

Myrtle Beach

Ocean Forest Hotel

SOUTH CAROLINA MEDICAL ASSOCIATION COMMITTEES 1950-51

COMMITTEE ON LEGISLATION AND PUBLIC POLICY

Dr. D. Strother Pope, Columbia, Chairman
Dr. Rowland F. Zeigler, Jr., Florence
Dr. John K. Webb, Greenville
Dr. W. O. Whetsell, Orangeburg
Dr. R. L. Sanders, Columbia

MEMORIAL COMMITTEE

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Dr. W. T. Brockman, Greenville
Dr. A. W. Browning, Elloree

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Dr. Hilla Sheriff, Columbia, Secretary
Dr. A. Wells Lowman, Denmark
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Dr. C. R. F. Baker, Sumter, Chairman
Dr. J. K. Owens, Bennettsville
Dr. A. B. Preacher, Allendale

COMMITTEE ON INDUSTRIAL HEALTH

Dr. J. G. Murray, Greenville, Chairman
Dr. Allen C. Wise, Saluda
Dr. J. S. Liverman, Lexington

COMMITTEE ON RURAL HEALTH

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Dr. H. L. Peeples, Scotia
Dr. H. W. Mims, Monck's Corner

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Dr. O. B. Mayer, Columbia
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COMMITTEE ON HOSPITAL SERVICE

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CANCER CONTROL COMMISSION

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Dr. A. G. Brown, Rock Hill
Dr. P. D. Hay, Florence
Dr. W. J. Snyder, Jr., Sumter
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COMMITTEE ON A PRACTICAL MEDICAL CURRICULUM

Dr. George R. Wilkinson, Greenville, Chairman
Dr. John F. Rainey, Anderson
Dr. Stuart Shippey, Rock Hill

MEMBERSHIP COMMITTEE

Dr. William Weston, Jr., Columbia, Chairman
Dr. Charles R. May, Bennettsville
Dr. R. L. Crawford, Lancaster

COMMITTEE ON INDUSTRIAL MEDICAL FEE SCHEDULE

Dr. Frank C. Owens, Columbia, Chairman
Dr. Charles Wyatt, Greenville
Dr. W. S. Judy, Greenville
Dr. Henry F. Hall, Columbia

PROGRAM COMMITTEE

Dr. David F. Adcock, Columbia, Chairman
Dr. W. R. Tuten, Jr., Fairfax
Dr. N. B. Heyward, Columbia, S. C.

COMMITTEE ON MILITARY SERVICE

CHAIRMAN
Dr. Frank C. Owens, 1319 Laurel St., Columbia, S. C.

1st Judicial District
Calhoun, Orangeburg, Dorchester
Dr. L. P. Thackston, 557 Carolina Ave., N. E., Orangeburg, S. C.

2nd Judicial District
Aiken, Barnwell, Bamberg
Dr. Wallis Cone, Williston, S. C.

3rd Judicial District
Lee, Sumter, Clarendon, Williamsburg
Dr. N. O. Eaddy, 201 N. Washington St., Sumter, S. C.

4th Judicial District
Chesterfield, Marlboro, Darlington, Dillon
Dr. P. M. Kinney, Bennettsville, S. C.

5th Judicial District
Kershaw, Richland
Dr. C. A. West, 315 DeKalb St., Camden, S. C.

6th Judicial District
York, Chester, Lancaster, Fairfield
Dr. Roderick Macdonald, 330 E. Main St., Rock Hill, S. C.

7th Judicial District
Cherokee, Spartanburg, Union
Dr. H. L. Poole, 324 St. John St., Spartanburg, S. C.

8th Judicial District
Laurens, Newberry, Greenwood, Abbeville
Dr. J. C. Scurry, Hampton & W. Cambridge Sts., Greenwood, S. C.

9th Judicial District
Berkeley, Charleston
Dr. O. B. Chamberlain, Medical College, Charleston, S. C.

10th Judicial District
Oconee, Anderson
Dr. T. R. Gaines, 126 E. Earle St., Anderson, S. C.

11th Judicial District
McCormick, Edgefield, Saluda, Lexington
Dr. W. W. King, 302 Saluda Ave., Batesburg, S. C.

12th Judicial District
Florence, Marion, Horry, Georgetown
Dr. I'On Weston, Wine St., Mullins

13th Judicial District
Greenville, Pickens
Dr. W. W. Edwards, 103 E. North St., Greenville, S. C.

14th Judicial District
Colleton, Hampton, Jasper, Beaufort, Allendale
Dr. G. C. Brown, Jr., Walterboro, S. C.

Ex Officio members—Dr. W. R. Tuten, President, Fairfax; Dr. N. B. Heyward, Secretary, 1329 Blanding, Columbia; Mr. M. L. Meadors, Business Manager, West Cheves Street, Florence, S. C.

EASTER SEALS AT WORK

A four year old girl from Calhoun County, Patricia Zeagler, has been selected as the 1951 Easter Seal Girl of South Carolina, a living symbol of how the annual Easter Seal Campaign helps millions of crippled children toward their goal for happy useful lives.

Patricia is the daughter of Mr. and Mrs. O. K. Zeagler, Jr. of Lone Star. A beautiful little girl, she had the misfortune to suffer gangrene poisoning when she was about a year old. Amputation below the right knee followed. She has been using a caliper since 1948. This will be replaced with an artificial limb soon.

A precious child, Patricia is today happy and in excellent physical condition. Her prospects for a normal adult life are good.

Children like Patricia, in every section of the state, have received assistance because of Easter Seals, which extend and supplement, but do not duplicate the work of other agencies.

Give Now!

Can you think of a finer way to celebrate Easter? Your gift will bring new life, new hope to handicapped children. So many children need proper medical care and special training. Give generously now.

18th Annual EASTER SEAL APPEAL....
Feb. 25 to Mar. 25